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IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONER

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Opinion Below

The Opinion of the Court of Appeals is reported at 493 F.2d 507. No opinion was rendered by the District Court for the Northern District of Florida.

Jurisdiction

The opinion and judgment of the Court of Appeals for the Fifth Circuit were entered on April 26, 1974, and copies thereof were appended to the Petition for Writ of Certiorari. The Petition was filed July 25, 1974, and was granted on October 21, 1974. The jurisdiction of this Court rests on 28 U.S.C. §1254(1).

Questions Presented

(1) Whether there is a constitutional right to treatment for persons involuntarily committed to a state mental hospital.

(2) Whether, assuming there is a constitutional right to treatment, the patient in this case waived that right.

(3) Whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act.

Constitutional Provisions Involved

Constitution of the United States of America, Amendment XIV, §1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws.

Statutory Provisions Involved

42 U.S.C. §1983:

> Every person, who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

28 U.S.C. §1343(3):

> To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States.

Statement of the Case

Kenneth Donaldson, the Respondent, was involuntarily committed to the Florida State Hospital, Chattahoochee, Florida, on January 3, 1957, by a county court judge of Pinellas County, Florida, pursuant to Chapter 394, Florida Statutes, which provided for release upon application by himself, guardian, spouse, parent or next of kin. Such release was conditioned upon there being no objection from the head of the hospital. (§394.21, A. 242). Alternatively, release could be effected by a restoration to mental competency by certificate of three members of the medical staff attested by the superintendent. (§394.22, A. 242). These procedures assumed that the patient had recovered his reason or would pose no danger to himself or others.

The commitment order stated his incompetency was due to paranoid schizophrenia with auditory and visual hallucinations and delusions. The order further stated that Donaldson, then age 50, a resident of four years, required restraint to prevent self-injury or violence to others. Two physicians served as the investigating committee for the proceedings. (A. 187).

Prior to the Florida commitment, Donaldson had been a patient at Marcy State Hospital in New York from March 12, 1943, to June 26, 1943. At that time, his problems were described as auditory hallucinations, ideas of reference, and delusions of persecution. The medical description was Dementia Praecox, Paranoid Type, presently called Schizophrenic Reaction, Paranoid Type.

In January, 1957, at the time of his admission to Florida State Hospital, Donaldson was examined by a Dr. Clark Adair. The examination revealed that Donaldson expressed delusions of persecution for which he blamed "rich Republicans" and believed that the "Foreign Policy Association" had attempted to poison him by placing chemicals in his food. The diagnosis was Schizophrenia, Paranoid Type. (A. 187-193).

At the time of his admission, Donaldson, a Christian Scientist, requested that no medicine or shock therapy be administered and he consistently refused

repeated offers of such forms of therapy during his commitment. In addition, he frequently refused offers of other non-medical forms of therapy as well. (A. 25, 38, 52-7, 75, 95, 114-5, 122-6, 145, 152).

At the time Donaldson was admitted to the hospital in 1957, the Petitioner, Dr. O'Connor, was Assistant Clinical Director. He was in charge of the ward where Donaldson was assigned upon admission. In that position, Dr. O'Connor was Donaldson's attending physician. Dr. Gumanis, a co-defendant below, was a staff physician. (A. 103-105, 154).

On July 1, 1959, Dr. O'Connor became Clinical Director of the hospital, and later that year, Dr. Gumanis succeeded him as Donaldson's attending physician. Dr. O'Connor was subsequently promoted to Superintendent of the hospital on July 30, 1963, and served in that capacity until he retired February 1, 1971. Dr. Gumanis served as Donaldson's attending physician until April 18, 1967. At that time, Dr. Israel Hanenson became Donaldson's attending physician until Dr. Hanenson's death in the fall of 1970. From that time until his release on July 31, 1971, Donaldson was treated by Dr. Jesus Rodriquez. (A. 103-105, 154).

In 1959, Florida State Hospital at Chattahoochee provided services for 1,736,540 patient days per year. In 1970, Florida State Hospital provided services for 1,351,000 patient days per year,

compared to 21,790 patients days in the psychiatric section of one of Florida's largest, non-government hospitals, Tampa General Hospital, for the fiscal year 1967-68.

During Mr. Donaldson's assignment to Department A of Florida State Hospital, there were two doctors available; making a doctor patient ratio, at times, of 560/1000 patients for each doctor. In 1960, two doctors were responsible for 1000 patients. Previously, only one doctor had this responsibility. During Donaldson's stay in Department C of the hospital, there was one physician and one psychiatrist for approximately 800 patients.

In 1970, Florida State Hospital provided services for 1,351,000 patient days per year with a staff of 17 psychiatrists, seven physicians, and four psychologists, a total of 28 legislatively approved treating-type positions. Only 50% of each doctor's time was available for psychiatry. The remainder had to be devoted to medical matters and administration.

The American Psychological Association describes the optimum doctor-patient ratio to be one psychiatrist for each 50 acutely ill patients and one psychiatrist for each 125 chronically ill patients. There were approximately 200-500 acutely ill patients alone at Florida State Hospital during the time in question here.

Throughout the time Dr. O'Connor was Donaldson's attending physician, Donaldson continued to refuse to receive medication and shock treatment due to religious views. It should be noted that a prior exposure to such treatment in New York had been somewhat successful. This refusal continued when Dr. Gumanis assumed responsibility in 1959. During the approximately six and one-half years Donaldson was in Dr. Gumanis' care, written notes indicate he had consultation with staff doctors at least 51 times. Testimony at trial indicated that many other consultations probably occurred, but were not recorded.

Psychological examinations conducted in 1960 and 1961 showed no significant change from previous findings of incompetency. During June, 1963, Helping Hands, a Minneapolis group, requested information about Donaldson and sought his release. Dr. Gumanis and Dr. O'Connor denied the suggested release because Donaldson continued to require strict supervision. Psychological tests administered in 1964 continued to show no significant changes in Donaldson's condition. An earlier test, scheduled late in 1963, had been refused by Donaldson. (A. 230-241)

During January, 1964, a meeting of nine members of the staff recommended continued hospitalization. The written opinion of the staff, issued following

the meeting with Donaldson, found him dangerous to others and recommended further hospitalization. Donaldson complained to a member of the state legislature who subsequently arranged an interview and examination by an independent psychiatrist, Dr. Franklin J. Calhoun. Dr. Calhoun concluded:

> That the results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. This man has the type of mental illness that is most difficult for lay persons to detect. Even a psychologist or psychiatrist could be 'fooled' by Mr. Donaldson unless certain types of psychological tests are included in the evaluation. Unless his condition has greatly improved since my examination, I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized. (A. 222, 195-196).

During the summer of 1964, a Mr. John Lembcke, a certified public accountant, in Binghamton, New York, and a former classmate of Donaldson's at Syracuse University in the 1920's, began seeking Donaldson's release. Mr. Lembcke made four attempts between 1964 and 1968 to obtain Donaldson's release. All requests for release were denied due to the opinion of the staff that Donaldson was

dangerous to himself and others, and required strict supervision and treatment which they believed Mr. Lembcke would be unable to provide. (A. 82-97).

During 1966, Donaldson again refused a psychological examination and continued to refuse traditional forms of medication and shock therapy, but did participate in mileau therapy, religious therapy and recreational therapy. (A. 115).

On April 18, 1967, Donaldson was placed under the care of Dr. Hanenson who ordered another set of psychological tests. The examination, conducted July 13, 1967, showed no significant improvement in Donaldson's condition. Dr. Hanenson ordered another test sequence on March 13, 1968, at which time Donaldson showed the first signs of improvement since 1957. Possible trial visits were suggested. On March 21, 1968, Dr. Hanenson presented Donaldson to a staff meeting. The staff found improvement in his condition and suggested trial visits. Although Donaldson was approved for trial visits, Dr. O'Connor rejected Mr. Lembcke's suggestions of a complete release.

On September 9, 1968, Donaldson was given to a work assignment and granted grounds privileges. Testing conducted during November, 1969, indicated release at an early date. A report was submitted to Dr. O'Connor on February 6, 1970, and another, summarizing all psychological

testing was submitted on March 27, 1970. Another physician, Dr. F. D. Walls, examined Donaldson and reported unfavorably on March 27, 1970. During the fall of 1970, at the death of Dr. Hanenson, Dr. Jesus Rodriquez assumed the position of Donaldson's attending physician. He evaluated Donaldson and noted that he had again refused to work,had refused group therapy and refused other suggested forms of therapy. (A. 152, 204).

On March 4, 1971, Donaldson was again assigned to a general routine work assignment. On July 1, 1971, Dr. Milton J. Hirshberg assumed the post of Superintendent of Florida State Hospital. He examined Donaldson on July 26, 1971, and declared him to be a schizophrenic, paranoid type, in remission and recommended his release. Kenneth Donaldson was released from Florida State Hospital on July 31, 1971.

Prior to the present case, Kenneth Donaldson had brought fifteen separate petitions for a writ of habeas corpus in the state courts of Florida and lower federal courts.[1] All petitions were unsuccessful and on four occasions Donaldson petitioned this Court for a writ of certiorari.

The series began in 1960 when the

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[1] Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623, 635-636 (1971).

Florida Supreme Court denied a writ of habeas corpus refusing to openly state whether there is, or is not, a constitutional right to treatment. This Court denied certiorari. *In re Donaldson*, 364 U.S. 808 (1960). Similar denials of a writ of habeas corpus were also brought before this Court in 1963 and 1968. *Donaldson v. Florida*, 371 U.S. 806 (1963); *Donaldson v. O'Connor*, 390 U.S. 971 (1968).

In 1970, Donaldson, represented by counsel, again sought review of his case. Certiorari was again denied. *Donaldson v. O'Connor*, 400 U.S. 869 (1970). During this same period, at least three other cases in which various courts had refused to rule on the issue of whether there exists a constitutional right to treatment were brought before this Court. In each case, certiorari was denied. *People ex rel Anonymous v. LaBurt*, 385 U.S. 936 (1966); *United States ex rel Stephens v. LaBurt*, 373 U.S. 928 (1963); *People ex rel Anonymous v. LaBurt*, 369 U.S. 428 (1962).

This suit was initiated in the District Court for the Northern District of Florida prior to Donaldson's release on July 31, 1971. The initial complaint was styled a class action on behalf of all patients in Department C of the Hospital. In addition to damages, for Donaldson and the class, the complaint sought habeas corpus relief as to Donaldson and the class, and injunctive relief requiring the hospital to provide adequate treatment. After Donaldson's release, the

District Court dismissed the case as to the class action allegations, and the first amended complaint was filed on August 30, 1971. The amended complaint sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. Jurisdiction was alleged pursuant to 42 U.S.C. §1983, 28 U.S.C. §1343(3), and 28 U.S.C. §§ 2281, 2284. The amended complaint also asked the district court to convene a three-judge court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30, however, the plaintiff in a memorandum brief, abandoned the prayer that a three-judge court be convened. The prayers for injunctive and declaratory relief were eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward Plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights." The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference

that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization." Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on that verdict, Gumanis and O'Connor separately appealed to the United States Court of Appeals for the Fifth Circuit. The Judgment of the District Court was affirmed on April 26, 1974. (493 F.2d 507). Appellant Gumanis filed a timely Motion for Rehearing which had not been ruled on by the Court as of the time of this Brief was filed. Appellant O'Connor filed a timely Petition

for Writ of Certiorari in this Court on July 25, 1974, which was granted October 21, 1974.

Summary of Argument

I.

The essential question to be decided here is whether there exists a constitutional right to treatment for involuntarily civilly committed mental patients. The Court of Appeals ruled that such a right does exist as the *quid pro quo* of confinement. Petitioner argues that the alleged right to treatment is incapable of definition, implementation or enforcement due, in large part, to the uncertain nature of psychiatry.

II.

The second phase of the argument is concerned with the problem of whether, assuming the existence of a right to treatment, some involuntarily committed mental patients should be considered competent to waive that right. Further this portion is concerned with whether Donaldson, by word and deed, effectively waived his right to treatment. Petitioner submits that Donaldson's many refusals of treatment constituted an effective waiver of the right and that he should not have been heard to complain of a denial of treatment.

III.

The final portion of the argument is concerned with the retroactive application of the alleged right to treatment which occurred in this case. Prior to 1971, the year of Donaldson's release, there had been no judicial pronouncements of a right to treatment. Indeed, the first time a Court of Appeals had so ruled was in this case. Petitioner submits that it was unjust to establish the right and then proceed to enforce it in retrospect in a case involving individual monetary liability of a state employee. Petitioner further argues that he was acting in good faith pursuant to what he believed was proper procedure and should not be held liable for failure to predict the emergence of a new and controversial constitutional right.

ARGUMENT

I.

THERE IS NO CONSTITUTIONAL RIGHT TO TREATMENT FOR PERSONS INVOLUNTARILY CIVILLY COMMITTED TO A STATE MENTAL HOSPITAL.

A. The basis of the decision below.

The Court of Appeals held that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. [2] The Court of Appeals found that civil commitment entails a "massive curtailment of liberty" in the constitutional sense, citing *Humphrey v. Cady*, 405 U.S. 504 (1972), and noted that the due process clause of the Fourteenth Amendment to the United States Constitution guarantees a right to treatment upon a two-part theory.

The first part of the theory is concerned with the rationale for confinement. In its discussion, the Court of Appeals noted that three distinct

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[2] 493 F.2d 507, 520.

grounds are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care," "custody," or "supervision." The Court placed these grounds into two categories; one a "police power" rationale for confinement, the other a "*parens patriae*" rationale. Danger to others was considered a "police power" rationale; need for care or treatment a "*parens patriae*" rationale; and danger to self as an area combining elements of both. The Court reasoned that where, as in Donaldson's case, the basis for confinement evokes the *parens patriae* rationale, that the patient is in need of treatment, the due process clause requires that the deprivation of liberty brought on by commitment be accompanied by treatment. It was this theory the Court applied in this case notwithstanding an express finding in Donaldson's original commitment papers that he required "...restraint to prevent him from self-injury or violence to others..." and considerable evidence that numerous physicians felt Donaldson was dangerous to others, which would bring elements of the police power rationale into consideration.

The second part of the theory is concerned with the traditional limitations on a government's right to confine -- that confinement be in retribution for a specific offense; that it be limited to a fixed term; and that it follow a proceeding where

fundamental due process safeguards are present. Ignoring the due process protections inherent in the initial commitment hearing, the Court of Appeals found that where such limitations are absent, such as in an involuntary civil commitment to a state mental hospital, there must be a *quid pro quo* extended by the government to justify confinement. The Court then noted that the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment. [3]

B. Historical treatment of the mentally ill.

A discussion of whether there exists a constitutional right to treatment requires a brief examination of the historical basis for involuntary hospitalization of the mentally ill.

Insanity and the necessary care of the insane has been one of society's problems from the earliest of times. There are Biblical references to the primitive practice of driving the unfortunates out into the wilds to care for themselves, die from want, fall prey to wild animals, or revert to a condition little above the animals themselves, as in the case of the Babylonian king, Nebuchadnezzar. [4] As

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[3] 493 F.2d 522.

[4] Daniel 4:33

late as the time of Christ, the insane were found living in caves and abandoned tombs and were often a problem to the neighborhood. [5]

Some enlightenment had occurred by the time of Blackstone and Lord Coke. Coke noted, and Blackstone endorsed the view, that the execution of a madman "should be a miserable spectacle, both against law, and of extreme inhumanity and cruelty, and can be no example to others." [6]

Later, in 1603, Lord Coke described the law of insanity as it had developed in England and discussed the Statute de Praerogation Regis, which explicated the King's authority over the property of the mentally ill and outlined the King's duty to care for them in *Beverly's Case*, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603). Later, during the Eighteenth century, confinement was a privilege reserved for the more affluent. According to Blackstone, one applied for confinement only when the disorder was regarded as permanent and the individual could afford the cost of such confinement. [7]

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[5] Mark 5:2-5; Luke 8:27-29.

[6] 6 Coke's Third Inst. (4th ed. 1797); 4 Blackstone's Commentaries (Lewis ed. 1897).

[7] 1 W. Blackstone, *Commentaries*, 303-07 (9th ed. 1783); 2 F. Pollack & F. Maitland, *The History of English Law* (2nd ed. 1911).

During the Colonial period in the United States, families were expected to care for the mentally ill. In the absence of family the Colonial community would not provide care, but would attempt to send the individual back to where he or she came from. In Governor Winthrop's Journal, it is reported that on December 11, 1634, "[o]ne Abigail Gifford, sent by ship into this country, and being found to be somewhat distracted, and a very burdensome woman, the governor returned her to England by warrant to the same parrish, in the ship Rebecca." [8] Some years later, the Massachusetts Bay Company enacted legislation for the detention of violent persons so "that they do not damnify others," [9] the rationale being that if the individual was a threat to the community, the community could act accordingly.

The emergence of the idea of danger within the purview of organized medicine appears to have been accomplished in 1769 when the first institution for the insane was opened at Williamsburg,

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[8] I Winthrop's Journal, p. 144, Reprinted in the *History of New England 1630-1649*, by the Massachusetts Historical Society.

[9] 5 *Records of the Governor and Company of the Massachusetts Bay in New England* 80 (1854).

Virginia. The chartering act made specific reference to the need for restraining those "who may be dangerous to society." [10] The community's role in providing for the violent and insane who could not be maintained properly by their families was clearly established at that early time. The emphasis remained on detention, rather than treatment.

Detention was apparently rarely challenged in the early days of our nation. One of the first cases was brought in 1845 when Josiah Oakes petitioned the Massachusetts Supreme Court by writ of habeas corpus to determine the legality of his confinement. *In re Josiah Oakes*, 8 L.Rep. 123 (1845-46). Although the attending physician could not predict with any degree of certainty that Oakes would indeed engage in a dangerous act were he not confined, the Court relied on the *possibility* of danger as a decisive factor against him. The Court ruled that restraint was permissible because "the right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those who goings at large would be dangerous to themselves and others." The Court further states:

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10 A. Miles, *An Introduction to Public Welfare* 79 (1949).

> The necessity which creates the law, creates the limitations of the law. The question must then arise in each particular case, whether a patient's own safety or that of others requires that he should be maintained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. That is the limitation and the proper limitation.

The basis of a state's right to confine mentally ill persons against their will rests upon the dual reasons of (1) the power of the state in its role of *parens patriae*, and (2) its duty to protect under the police power. [11] A state has an obvious interest in the safety of all citizens and the maintenance of a healthy and productive citizenry. It might be argued that the *parens patriae* theory alone cannot justify confinement without benefit to or treatment of the individual, [12] but it

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11 Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 Mich.L.Rev. 945 (1959).
Note: *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv.L. Rev. 1288 (1966).

12 Note:*The Nascent Right to Treatment*, 53 Va.L.Rev. 1134 (1967).

cannot be reasonably or responsibly argued that society does not have the right under the police power theory to confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment.

The origins of insanity were, by 1873, still much a mystery to physicians, laymen and the courts alike as evidenced by the following quotation which appeared in *Mutual Life Ins. Co. v. Terry*, 15 Wall. 580, 21 L.Ed. 236 (1873):

> The causes of insanity are as varied as the varying circumstances of man.
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> '...some for love, some for jealousy, for grim religion some, and some for pride, Have lost their reason; some for fear of want, Want all their lives; and others every day, For fear of dying, suffer worse than death.'

Treatment, as a goal of confinement of mentally ill persons, emerged with the development of psychiatry as a medical specialty and the successful development of drug and shock therapy during the first half of this century. At this point, the states began to provide such care as was possible within the limitations of state resources. [13]

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[13] G. Zolborg, *A History of Medical Psychology*, (1941).

C. The emergence of the right to treatment theory.

The idea that there exists a constitutional right to treatment for the involuntarily committed mental patient was first set forth in 1960 in an editorial in the American Bar Association Journal. [14] The editorial has as its impetus an article of Dr. Morton Birnbaum, of the New York Bar, appearing in the same issue. [15]

In his initial article, Dr. Birnbaum suggested the need for recognition of a right to treatment and based his suggestion on the realization that care in state mental hospitals is often substandard. Dr. Birnbaum recognized that inadequate treatment does not often result from individual action by the medical staff, but from inadequate legislative funding:

> As the law has not recognized this right, the state can, and generally does, compel the public mental institution to give adequate medical treatment to its inmates. The state does this: (A) by compelling the institutionalization

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[14] Editorial, *A New Right*, 46 A.B.A.J. 516 (1960).

[15] Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

> of those persons whom it considers to be sufficiently mentally ill to require institutionalization for care and treatment; and, (B) by not appropriating sufficient funds to enable the public mental institution to obtain the number of competent personnel and to maintain the adequate physical plant that is necessary to provide therapeutic, rather than custodial, care for these sick people.
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> * * *
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> In too many cases, the efficacy of modern medicine is dependent upon a legislative decision rather than upon medical knowledge. If the legislature appropriates sufficient funds to enable the public mental institution to provide proper medical care, the effect of institutionalization is decided to a great extent by the limitations of medical knowledge. If the legislature appropriates insufficient funds, the effect of institutionalization is decided to a great extent by legislative fiat.

The article further suggests that assuming recognition of a right to treatment, that the proper form of remedy would be release, pursuant to

habeas corpus proceedings, for those receiving inadequate care. It was thought that the prospect of wide-scale release of mentally ill persons would force the states to either provide adequate care or abandon public mental health institutions altogether. Dr. Birnbaum noted the obvious threat to the health and welfare of the general citizenry and patients, but felt that such action was justified by the eventual improvement of public institutions.

At the conclusion of his article, Dr. Birnbaum noted several problems with the recognition and enforcement of a right to treatment. The most important of these was the practical realization that in order to avoid the problem of wide-scale release of mentally ill persons and other injustices, that the courts should provide a reasonable interim period between recognition of the right and enforcement of the right.

There was no judicial recognition of a constitutional right to treatment for several years following Dr. Birnbaum's suggestion of such a right. In 1966, the Court of Appeals for the District of Columbia held in *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), that a patient committed involuntarily to a mental hospital under a District of Columbia Statute had a statutory right to treatment pursuant to the District of Columbia 1964 Hospitalization of

the Mentally Ill Act. [16] In addition, Judge Bazelon, writing for the majority, stated that, even absent such a statute, forced confinement in a public mental hospital without treatment might violate either the due process clause, the equal protection clause, or the Eighth Amendment. Since 1966, the District of Columbia Circuit has reaffirmed its holding in Rouse v. Cameron, *supra*, on several occasions. [17]

Several other district courts have also considered the question of whether there is a constitutional right to treatment capable of definition and deliniation. The resulting decisions and remedies have not been uniform. The Court in *Rouse* felt that *habeas corpus* relief would be the proper remedy for a present patient not receiving adequate rehabilitative treatment and examined the treatment on a subjective, individual patient basis. Subsequent cases such as *Welsch v. Likens*, 373 F.Supp. 483 (D.Minn. 1974),

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16 D. C. Code Ann. §21-562 (1967).

17 *In re Curry*, 452 F.2d 1360 (D.C. Cir. 1971); *Covington v. Harris*, 419 F.2d 617 (D.C.Cir. 1969); *Tribby v. Cameron*, 379 F.2d 104 (D.C.Cir. 1967); *Dobson v. Cameron*, 383 F.2d 519 (D.C. Cir. 1967); *Millard v. Cameron*, 373 F.2d 468 (D.C.Cir. 1966).

and *Stachulak v. Coughlin*, 364 F.Supp. 686 (N.D.Ill. 1973) also focus on institutional reform rather than individual treatment. Another district court rejected the proposed right to treatment as completely unworkable in *Burnham v. Department of Public Health*, 349 F.Supp. 1335 (N.D.Ga. 1972). This decision was recently reversed and remanded based upon the decisions of the Court of Appeals for the Fifth Circuit in *Wyatt v. Aderholt*, --F.2d--, (11/8/74), and the present case. The present case represents the first instance in which a former patient has sought and received damages from individual state psychiatrists upon a theory that they confined him knowing he was not receiving adequate treatment and that absent such treatment the period of his confinement would be prolonged. This radical departure from institutional remedies raises frightening implications for staff and patients alike. Competent staff will be driven away from inadequate institutions, leaving the patients with little hope of a cure, dumped into the often unwilling or unprepared hands of their families.

D. The difficulties of defining and enforcing a consitutional right to treatment for mental patients.

However attractive the theory of a right to psychiatric treatment may be to all persons concerned with the

preservation of individual liberties, serious problems arise from the attempted application and enforcement of such a right. These problems are of both a legal and medical nature and have been the subject of considerable commentary. [18]

The overriding problem in defining and applying a right to treatment lies in the problem of judges and juries untrained in medicine and the highly specialized field of psychiatry attempting to second guess the judgment of trained physicians and psychologists concerning what constitutes "adequate treatment."

As early as 1942, over forty (40) distinct methods of psychotherapy were accepted by the medical profession. [19]

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[18] Szasz, *The Right to Psychiatric Treatment: Rhetoric and Reality*, 57 Geo.L.J. 740 (1969); Cameron, *Non-Medical Judgment of Medical Matters*, 57 Geo.L.J. 716 (1969); Note, *Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right*, 32 Md.L.Rev. 42 (1972); Katz, *The Right to Treatment--An Enchanting Legal Fiction*, 36 U. of Chi. L.R. 755 (1969).

[19] M. Levine, *Psychotherapy in Medical Practice*, 17-19 (1942). 1-4, *Current Psychiatric Therapies* (J. Masserman ed. 1961-64).

These methods listed by a text range from active physical treatment such as "shock therapy" to more subtle forms of therapy such as ignoring certain symptoms and attitudes. Dr. Thomas S. Szasz observes the difficulties involved in presently defining what constitutes "illness," "treatment," and "patient" are severe enough without the confusing injection of an indefinable right to treatment. [20] As Dr. Szasz points out that it is extremely difficult to determine not only whether certain behavior constitutes "illness" but to determine what constitutes the best method of treatment or whether the chosen treatment is "adequate."

Dr. Szasz believes that what is termed a "right" to treatment should be labelled a "claim" for treatment and points out that a "right" to treatment for the patients would seriously impair a physician's prerogatives of choosing his patients and methods of treatment. This conflict is heightened in a state mental hospital where a physician cannot choose his patients.

The impossibilities of judicial definition and application of a right to treatment were discussed by now Chief Justice Burger in *Lake v. Cameron*, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966):

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[20] Szasz, *The Right to Health*, 57 Geo. L.J. 734, 741, 743.

> ...this Court now orders the District Court to perform functions normally reserved to social agencies by commanding search for a judicially approved course of treatment or custodial care for this mentally ill person who is plainly unable to care for herself. Neither this Court nor the District Court is equipped to carry out the broad geriatric inquiry proposed or to resolve the social and economic issues involved.

It has been strenuously argued in this and preceding cases that expert testimony is sufficient to guide a judge or jury to a proper determination as to what constitutes proper and adequate treatment in any specific case. The Court of Appeals accepted and applied that theory in this case. While the testimony of experts and guidelines formulated by professional associations may be helpful in determining the adequacy of care provided by an entire hospital or system such as in an inquiry as in Wyatt v. Stickney, *supra*, it cannot be easily applied to an individual patient. To attempt such application is to subject the professional judgment and decisions of a trained physician to the scrutiny of untrained laymen. It is common knowledge that any two physicians rarely treat any individual in the identical manner. One physician may consider some form of active treatment essential while another may choose to treat the symptoms by ignoring them.

A graphic illustration of a court faced with two widely divergent expert views on proper treatment, raised in the context of incompetence to stand trial, is provided in *United States v. Klein*, 325 F.2d 283, 286 (2nd Cir. 1963), wherein the Court lamented:

> Mental disorders being what they are, it is not surprising that eminent psychiatrists differ as to methods of treatment. Here Dr. Shoefield believed Klein would respond to a more psychoanalytic form of therapy; Dr. Douglas, by his own testimony, favored a more physiological approach. Courts of law, unschooled in the intricacies of what may be the most perplexing of medical sciences, are ill-equipped to choose among such divergent but responsible views. In a case like this, where a man's life may literally hang in the balance, a judge ought not undertake the hazardous venture of changing the course of psychiatric treatment without, at the least, a much fuller hearing and a greater preponderance of expert testimony than existed here.

Advocates of the right to treatment tend to ignore the difficulties of laymen sitting in judgment of the decisions of trained physicians with the argument that any judge who can allocate AM radio frequencies to avoid electronic interference is capable of

determining, with the aid of experts, which manner of treatment is "adequate" or "proper." [21]

This argument ignores the difference between the more exact science of electronics and the vague, fluid theories of psychotherapy. While it may be possible to determine whether one radio station will interfere with another with some degree of certainty, it has been demonstrated above that it cannot be said with equal certainty that one method of treatment is superior to another in any particular case.

This Court recognized the dilemma in *Greenwood v. United States*, 350 U.S. 366 (1956), wherein Justice Frankfurter noted the transiency of psychiatry when reviewing the testimony of two psychiatrists, declaring:

> ...their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment....

An examination of portions of Donaldson's hospital records in the Appendix will reveal

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21 Bazelon, *Implementing the Right to Treatment*, 36 U.Chi.L.Rev. 742 (1969).

similar differences of opinion between the staff physicians.

Following the decision in *Rouse v. Cameron*, the American Psychiatric Association released a policy statement on the adequacy of treatment. [22]

The A.P.A. statement contends that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination," but sets forth seven considerations relevant to a determination of whether a patient is receiving adequate care: (1) The purpose of hospitalization, and differences between long-term and short-term treatment programs; (2) the degree to which treatment is changed as diagnosis develops during institutionalization; (3) the need to protect the patient from self-inflicted harm; (4) the importance of interrupting the disease process, as in separating the psychotic from his family stress situation; (5) the effective use of physical therapies; (6) efforts to change the emotional climate around the patient meaning "mileau therapy" and related measures; and (7) the availability of conventional psychological therapies. [23] The statement strongly

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22 American Psychiatric Association, *A Position Statement in the Question of Treatment*, 123 Am.J. Psychiatry, 1458 (1967).

23 *Id.* at 1458-1459

stresses the importance of considering the limitations of the staff and facilities at hand, and the absolute need for cooperation by the patient in his treatment program.[24]

The difficulties encountered by attempted judicial assessment of psychiatric treatment opinions and techniques reach the point of the ridiculous when, as in the present case, a court judicially declares a form of treatment long accepted by psychiatrists to be an "amorphous and intangible concept" frequently asserted by defendant psychiatrists as a concealment or smoke screen tactic. The Court emphasized its displeasure with "mileau therapy" citing a law review article, written by an attorney, as support for the notion that "mileau therapy" is an excuse used by psychiatrists to cover up a lack of adequate treatment.[25] Articles by physicians and psychiatrists take the opposite view that "mileau therapy" is often an excellent alternative or companion to medical or shock therapy.[26]

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24 *Id.* at 1459-1460.

25 Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 Geo.L.J. 782, 786-787, n. 19 (1969).

26 Cameron, *Nonmedical Judgment of Medical Matters*, 57 Geo.L.J. 716, 731 (1969); J. Frank, *Persuasion and Healing--A Comparative Study of Psychotherapy* (1961).

It has been suggested that it is no more difficult for a judge or jury to determine whether a patient has received "adequate" treatment than to hear a traditional medical malpractice case.[27] However, the analogy is not accurate. Physical medicine has a relative certainty compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine issues of treatment and great confusion in trying to decide when negligence has occurred. Most of the cases involve such matters as discharge or failure to prevent escape from an institution, not the superiority of one form of treatment or therapy over another.[28] When a patient sues the doctor or hospital for negligent treatment, as in shock therapy injury cases, there is no comparison of treatments, but rather an examination of how the particular treatment was administered.[29]

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27 *Rouse v. Cameron*, 373 F.2d at 457, n. 30.

28 J. Katz, J. Goldstein, & J. Dershowitz, *Psychoanalysis, Psychiatry, and Law*, 728-751 (1967).

29 CF. *Hammer v. Rosen*, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959).

Negligence, a traditional guiding point for courts and juries in medical malpractice litigation, will be missing from federal cases seeking to enforce a constitutional right to treatment because negligence cannot form the basis of jurisdiction under the Civil Rights Acts. *Smith v. Clapp*, 436 F.2d 590 (3rd Cir. 1970); *Isenberg v. Prasse*, 433 F.2d 449 (3rd Cir. 1970).

The difficulties of one District Judge in attempting to define and apply a right to treatment are described in *Burnham v. Department of Public Health*, 349 F.Supp. 1335 (N.D.Ga. 1972), *reversed and remanded*, --F.2d-- (5th Cir. 11/8/74), wherein Chief District Judge Smith explored the requirements of civil rights jurisdiction, the nature of the asserted right to treatment, and the impossibilities of its definition and responsible application. Judge Smith concluded that there exists no affirmative federal constitutional right to treatment. His decision was recently reversed and remanded by the Court of Appeals for the Fifth Circuit on the authority of their decision in this case and Wyatt v. Aderholt, *supra*.

Subsequent commentary highly recommends the approach taken by the District Court in *Burnham*.[30] Professor Reisner notes that while objective standards might be judicially developed to be applied to

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30 Reisner, *Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends*.

institutions as a whole, he concludes that judicial attempts to gauge the appropriateness of treatment offered to individual patients cannot help but encounter the difficulties foreseen by the *Burnham* court.[31]

The Court of Appeals for the Fifth Circuit brushed aside objections that courts are incapable of determining what constitutes "adequate" treatment with the view that since other courts had attempted to do so, it must be that the judiciary is perfectly capable of sitting in judgment of the professional decisions of trained physicians. The Court also noted that there were cases, declaring the case at bar to be one, where the jury could determine whether a patient has been denied his "rights" by comparing the care he received under one physician to that he received under another. Both theories place laymen in the position of psychiatrists and the latter does not, as the Court of Appeals suggests, avoid the determination of which treatment or therapy is "adequate" or "proper" in any particular case.

A jury cannot be expected to accurately evaluate which of dozens of valid, acceptable treatments is best or any particular patient. Indeed, no cause of action should arise under the Civil Rights Act, if the only question is whether the

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31 *Id.*

most appropriate treatment was applied.[32]

The Court of Appeals argued further that a jury would be justified in finding a denial of "rights" by concluding that the defendants below obstructed the release of a patient even though they knew he was not receiving treatment. This theory ignores the fact that physicians in a state mental hospital are required to accept all patients committed to their care and are not empowered to release a patient until he is "cured." Even though a doctor may realize that a patient is not receiving treatment, or does not benefit from the available treatment, due to lack of available staff, facilities, operating funds or other reasons, a doctor in a state institution simply lacks the statutory authority to release a mentally ill patient.

The Court of Appeals held that a *quid pro quo*, in the form of adequate treatment, must be advanced by the state in exchange for the liberty of the involuntarily committed mental patient. This theory ignores the realities providing the basic justification for involuntary confinement of the mentally ill. Involuntary commitment rests upon two interrelated foundations: (1) the "police power" of the state; and (2) the state's

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32 *Mayfield v. Craven*, 433 F.2d 873 (9th Cir. 1970).

role as "*parens patriae*." The two are not easily separated in this setting. Basically, when the state provides mental health facilities for its citizens it acts in *parens patriae*. When the state involuntarily commits a citizen to a state mental health institution, it acts pursuant to its traditional police powers to protect the general public. A state has a strong interest in a healthy, productive, educated society.[33] Accordingly, for the benefit and protection of society, the state provides for state custody and maintenance of incompetent persons. The state undertakes to care for those persons whose mental illness makes it difficult or impossible for them to care for themselves or to be cared for by their families, until such time as the patient is considered well enough to return to society. The state promises that and nothing more.

Professor Hugh Goffman has suggested, somewhat critically, that the true clients of state mental health facilities are the relatives of the patient, the police, and the judges.[34] This theory was noted

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33 *Penn Dairies v. Milk Control Commission*, 318 U.S. 261 (1943); *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

34 H. Goffman, Asylums -- *Essays on the Social Situations of Mental Patients and Other Inmates* 384 (1961).

rejected as morally and constitutionally unacceptable by the Court of Appeals for the Fifth Circuit in *Wyatt v. Aderholt*, --F.2d-- (5th Cir. 11/8/74). Consistent with its *quid pro quo* theory, the Court also rejected the theory that custodial care and safekeeping of mental patients is sufficient to justify confinement. This position ignores the fact that the historical basis for the existence of state mental health institutions was to safeguard the individual and society, and relieve the family of the financial and physical burden of caring for the mentally ill.[35]

The nature of treatment supplied beyond custodial care is a question for the states, not the federal courts. Whether a state shall provide a particular governmental service, and if so in what amount (qualitatively and quantitatively) are generally questions for the states and do not raise federal constitutional issues cognizable under 42 U.S.C. §1983, the Civil Rights Act of 1871, and 28 U.S.C. §1343(3).[36] It must be remembered that not every governmental

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35 Smoot, *Laws of Insanity*, §149 (1929).

36 *Fullington v. Shea*, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970); CF. *McGowan v. Maryland*, 366 U.S. 420 (1961).

function implies a corresponding right or "*quid pro quo*" as it has been termed by the Court of Appeals. *Collins v. Hardyman*, 341 U.S. 651 (1951); *Niklaus v. Simmons*, 196 F.Supp. 691 (D.Neb. 1961).

An analogous situation might be that of the public schools. School attendance is compulsory so it might be argued that there must, therefore, be a constitutional right to an adequate education as the *quid pro quo* to those persons forced to attend school. Definition of such a right might be equally incapable of accurate definition. However, the *quid pro quo* theory has not been extended to the public schools. There is no right to an education even though attendance is involuntarily compelled.[37]

It was admitted by Respondent, in the pleadings, that there is no statutory right to treatment in Florida, as in the District of Columbia statute before the court in *Rouse v. Cameron*. Petitioner further believes, that there can be no federal constitutional right to treatment, as demonstrated above. Petitioner has shown that aside from the problem of determining what constitutes mental illness, that there is a bewildering array of accepted methods of therapy and a wide divergence of opinion between respected

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37 *Fleming v. Admas*, 377 F.2d 975, 977, (10th Cir. 1967), *cert. den.* 389 U.S. 898 (1967).

experts as to which method may be proper in a particular case. A right must be capable of definition. The proposed right of treatment defies definition; its application and enforcement are impossible in the absence of a definition.

If the proposed right is to be enforced on the institutional level, such as in Wyatt v. Aderholt, *supra*, by imposition of certain standards drawn in terms of physical plant specifications and doctor-patient ratios, then there are no guarantees that treatment would be adequate on the individual level because the question of whether the particular forms of therapy applied are proper would still be open to argument. Conversely, if the proposed right is to be enforced on the individual level, as in this case, institution-wide reforms would be few and the process agonizingly slow. In addition, the courts would be forced into the position of picking and choosing among the various forms of therapy and, as in this case, overruling the decisions of trained psychiatrists in favor of some other form of therapy. Either choice of remedies serves to highlight the impossibility of serving the rights of all patients. One path favors the general interest of all at the expense of the individual, while the latter serves the individual interest at the expense of other patients and substitutes judicial wisdom for that of trained psychiatrists.

Given the manifold problems of definition and implementation, there can be no constitutional right to treatment. A right must be capable of enforcement. *Virginia Coupon Cases*, 114 U.S. 270, 303 (1885). The proposed constitutional right to treatment ignores the historical basis of state-provided mental health institutions, the difficulties of defining what constitutes adequate treatment, and the greater difficulties of fashioning a remedy which will provide such treatment to all patients. A constitutional right cannot rest upon such grounds.

II.

ASSUMING THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT, DONALDSON WAIVED THAT RIGHT.

Assuming *arguendo* that there exists a constitutional right to treatment, is there a corresponding right to refuse treatment? Or, may a mental patient, by word or deed, waive his right to treatment? Commentators suggest that a right to refuse treatment may be a necessary adjunct to the proposed right to treatment.[38] Statutes in Alaska and

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[38] Miller, Dawson, Dix and Parnas, *Cases and Materials on Criminal Justice Administration and Related Processes--The Mental Health Process*, 1663 (1971).

California expressly recognize a right to refuse on religious and other grounds.[39]

A natural question arises as to whether persons committed for reasons related to mental competency should be considered competent to consent to, or refuse offered treatment. California and Alaska statutes grant the patient the right to decide so long as the administrators determine that he is in such a "condition of mind as to render him competent to make the decision."[40] Law review proponents of a right to treatment generally refuse, in their zealous protection of the patient's right to treatment, to recognize the right of a patient to refuse treatment.[41]

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39 §7104, *California Wel. & Inst. Code*, (1969 Supp.); §47.30.130, *Alaska Statutes*, (1969 Supp.).

40 §7104, *California Wel. & Inst. Code.*

41 Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 Geo.L.J. 782, 801 (1969); Note, *The Nascent Right to Treatment*, 53 Va.L.Rev. 1134, 1140 (1967).

Petitioner would argue that assuming there exists a right to treatment, certain mental patients should be considered to be competent to waive that right, regardless of a prior judicial determination of legal incompetency. This argument sounds completely inconsistent, but finds practical support in recent decisions.

In *Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971), *cert. den.* 404 U.S. 985, the Court of Appeals upheld the claim of a practicing Christian Scientist who was involuntarily admitted to a hospital and given medication over her continued objections. The court noted that the patient had never been judicially declared imcompetent, but noted that where the patient's religious views pre-dated by some years any allegations of mental illness or incompetency and where there was no contention that the current mental illness in any way altered those views, there may well be no justification for ignoring the patient's wishes. The court noted the decision in *In re Brooks Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965), wherein the Illinois Supreme Court ruled that where approaching death has weakened the mental faculties of a theretofore competent adult to a point where he may be properly declared incompetent, he may not be compelled by a state appointed conservator to accept treatment of a nature which would probably save his life, but which is forbidden by his religious views and which he has steadfastly refused even though aware that death would result from such refusal.

This theory was carried forward in *Holmes v. Silver Cross Hospital of Joliet, Illinois*, 340 F.Supp. 125 (N.D.Ill. 1972), wherein an administratix brought suit under the Civil Rights Act of 1871 alleging that the civil rights of the decedent were violated when an appointed conservator authorized blood transfusions in spite of a prior request to the contrary by the deceased, made before losing consciousness. The court found that although the decedent was incompetent by reason of his state, that he was entitled to have his religious convictions honored in the absence of some substantial state interest. The court went on to suggest that a balancing test should be applied which would consider the status of any dependants and other factual information not before the court.

The Fifth Circuit rejected all claims of waiver as "without merit." 493 F.2d at 531. Such a position ignores the individual rights of Donaldson and other such patients. Some suggest that a right to treatment imposes a duty to be treated.[42] Justice Holmes supported that view stating:

> While there are in some cases legal duties without a corresponding right; we never see a legal

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42 Katz, *The Right to Treatment--An Enchanting Legal Fiction?*, 36 U. of Chi. L.R. 755 (1969).

> right without either a corresponding duty or compulsion stronger than duty.[43]

Whether there is a right to refuse treatment or a duty to be treated, the evidence in this case demonstrates conclusively that either Donaldson exercised his right not to be treated or he utterly failed in his duty to be treated. The record is replete with evidence that he not only continually refused medicine and shock therapy, but that he refused, at times, to participate in occupational and group therapies. (*Supra* at pp. 6, 10, 11) The Court in *Rouse v. Cameron* suggested that patient refusal to cooperate in therapy does not excuse lack of adequate treatment, but rather is a further indictment of the treatment facilities and staff. This attitude was prompted primarily by the requirements of the District of Columbia statute involved. However, the Court in *Wyatt v. Stickney* suggested that the same attitude should apply to the constitutional right to treatment. The *Wyatt* standard ignores the patient who refuses treatment or is unamenable to treatment.[44]

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43 Holmes, *Uncollected Letters*, 66. See also: *Ogden v. Saunders*, 12 Wheat. 213, 281-82 (1827).

44 325 F.Supp. 781, 784 (M.D.Ala. 1971).

While the courts and commentators do not believe patient cooperation is a key element of adequate treatment, the American Psychiatric Association believes patient cooperation is a necessity.[45] No involuntary patient becomes a true "patient" until he is willing to accept help and trust those who offer it. Some commentators have recognized this problem and have suggested that preventative detention may be the only viable alternative.[46]

Donaldson, having continued to refuse numerous types of treatment, including shock treatment which had apparently been a fairly successful element of his New York treatment, should not have been heard to complain of the "inadequacy" of his treatment. Therefore, even assuming the existence of a right to treatment, Donaldson could not present a valid claim. He failed to uphold his corresponding duty to be treated. His actions should have been construed as an effective waiver or repudiation of any right to treatment.

Any claim that all involuntary mental patients, committed following a judicial determination of incompetency, should also

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45 American Psychiatric Association, *Position and Statement on the Question of Adequacy of Treatment*, 123 Am.J.Psychiatry 1458 (1967).

46 Katz, *The Right to Treatment--An Enchanting Legal Fiction*, 36 U.Chi.L.Rev. 755, 762-763 (1969).

be considered incompetent to waive various forms of therapy or treatment is untenable and unconscionable. Such a position forces treatment upon those who would not have it, whether on religious or other grounds, and in so doing tramples the constitutional rights of members of the very class sought to be protected.[47]

The District Court placed the question of the effect of Respondent's refusals of treatment in the hands of the jury and the Court of Appeals rejected completely the theory of an incompetent asserting such rights. Petitioner would argue that the question of waiver is a crucial adjunct of the right to treatment argument and that neither the District Court or the Court of Appeals gave adequate consideration to this issue and its effect on the question of Petitioner's liability.

Considering the substantial evidence of either a waiver of treatment or, at least, a failure to cooperate with treatment, it is clear that Donaldson lacked a cause of action. The Motion for Directed Verdict made by counsel for Petitioner O'Connor at the close of the Plaintiff's case should have been granted.

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47 See, e.g., *Runnels v. Rosendale*, 499 F.2d 733 (9th Cir. 1974), citing *Roe v. Wade*, 410 U.S. 113 (1973); see also: *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973), citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Georgia*, 394 U.S. 557 (1968); and Roe v. Wade, *supra*.

III.

ASSUMING THE EXISTENCE OF A RIGHT TO TREATMENT, STATE EMPLOYED PSYCHIATRISTS SHOULD NOT BE HELD PERSONALLY LIABLE FOR A DEPRIVATION OF ADEQUATE TREATMENT.

The Court of Appeals held that it was not improper for the district court jury to have held Petitioner and Dr. Gumanis, the other Appellant below, personally liable for the alleged deprivation of adequate treatment although such deprivation was caused primarily by inadequate staffing and facilities.

Petitioner submits that a psychiatrist in a state mental hospital should not be held personally liable for the deprivation of a constitutional right, whose emergence and enforcement could not have been reasonably foreseen. Furthermore, psychiatrists in a state hospital should not be held liable for deprivation of a constitutional right to adequate treatment, when they have no control over the number or nature of the patients they must treat, the facilities and resources available to them, or the statutory right to either refuse to treat a particular patient or release a patient before he is restored to his mental health. The Court of Appeals found such considerations without merit.

Kenneth Donaldson was committed to Florida State Hospital in 1957 and released

in 1971. The first suggestion of a constitutional right to treatment arose in 1960,[48] a year after Dr. O'Connor left his position as Donaldson's attending physician to become Clinical Director and subsequently Hospital Superintendent. It was not until 1971, the year of Donaldson's release, that the first court held that there was a constitutional right to treatment. *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala. 1971). The *Wyatt* case dealt not with individual care, however, but with institutional standards, staffing and facilities. No Court of Appeals made a similar pronouncement until the decision below in this case. 493 F.2d 507 at 519.

The basic premise of Donaldson's case was, according to the Brief in Opposition to Petition for a Writ of Certiorari, that Dr. O'Connor deprived "Donaldson of his liberty...even though he knew Donaldson was receiving only...custodial care...." Such a case must be built upon the foundation of an existing right to treatment, yet there was no such right recognized until the year of Donaldson's release.

Dr. O'Connor acted according to what he believed to be the proper course, medically and legally. Custodial care of the mentally ill had been the accepted standard in this country until the last few years when the right to treatment theories began to circulate. Dr. O'Connor's

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48 Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

good faith reliance upon then-existing standards should be defense to this action. As noted in the writings of Justice Cardozo, such reliance should not be taken lightly:

> What has once been settled by a precedent will not be unsettled overnight, for certainty and uniformity are gains not lightly to be sacrificed. Above all is this true when honest men have shaped their conduct on the faith of the pronouncement.[49]

Similar sentiments were voiced in *Pierson v. Ray*, 386 U.S. 547, 557 (1967), wherein this Court held that state officers are not "charged with predicting the future course of constitutional law." State officers and employees must be required to act as reasonable and responsible men, but "they neither can nor should be expected to be seers in the crystal ball of constitutional doctrine.[50]

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49 Cardozo, *The Paradoxes of Legal Science* (1928).

50 *Pierson v. Ray*, 386 U.S. 547, 557 (1967); *Westberry v. Fisher*, 309 F.Supp. 12 (D.Me. 1970). See also: *Stone v. Egeler*, 377 F.Supp. 115 (W.D.Mich. 1973); *Eslinger v. Thomas*, 476 F.2d 225 (4th Cir. 1973); *Taylor v. Perini*, 365 F.Supp. 557 (N.D.Ohio 1972); *Skinner v. Spellman*, 480 F.2d 539 (4th Cir. 1973); *Collins v. Schoonfield*, 363 F.Supp. 1152 (D.Md. 1973); *McKinney v. Debord*, 324 F.Supp. 928 (E.D. Cal. 1970); *Clarke v. Cady*, 358 F.Supp. 1156 (W.D.Wis. 1973).

The controversy in this case centers around the effort to establish a right to treatment and demonstrate that Kenneth Donaldson was denied that right. The inequity arises when the right, if established, is applied retroactively to create monetary liability on the part of Petitioner and Dr. Gumanis. In essence, their wrongful acts, if any, consisted of the violation of a prospective right; assuming the present existence of a right to treatment. Justice Holmes once defined a prospective right as follows:

> A prospective right is not yet a right. It is only an expectation having certain intensity of reasonableness.[51]

It has been known for many years that state mental hospitals are woefully inadequate in terms of physical facilities, staff, and financing.[52] State mental hospitals are a creature and occasional victim of legislative fiat. They exist and operate on the funds made available

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51 *Southern Pacific R. R. Co. v. United States*, 189 U.S. 447, 450 (1903).

52 Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623 (1971); Birnbaum, *A Rationale for the Right*, 57 Geo. L.J. 752 (1969); Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Editorial, *A New Right*, 46 A.B.A.J. 516 (1960).

by the legislature, and have only as many staff members as allowed by the annual appropriations bill. The administrator and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order. They are not statutorily empowered to refuse any patient committed for care or discharge any patient who has not regained his mental health.

The personal liability that resulted in this case goes far beyond the original theory and conflicts with the statements of its creator and most ardent supporter, Dr. Birnbaum, who is of counsel in this case, and has long maintained that the understaffing and lack of physical facilities that plague state mental institutions and which lead to inadequate treatment, are not the fault of the individual psychiatrists or others who work under such conditions. [53]

Against just such a set of facts, the Court of Appeals found that a doctor in a state institution using the limited resources available to him, could be held personally liable for failing to give adequate treatment, as judged by a court of law.

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53 Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 500 (1960); accord, e.g. Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623, 628 (1971).

If the situation were not as serious as it is, it would be ludicrous to imagine a federal court finding that an over-worked, under-paid, staff psychiatrist in an over-crowded state hospital, working with a patient-staff ratio averaging five hundred patients per physician, using the meager facilities available to him, could be held personally liable in the amount of $23,000, to a former patient, for failing to foresee the existence of a previously unestablished constitutional right and failing to provide each and every patient with "adequate treatment", pursuant to that right, as determined by a group of laymen.

Respondent attempts to refute Petitioner's claim that he was not statutorily authorized to release Donaldson even though he knew that Donaldson was receiving inadequate treatment which would make recovery slower by pointing to evidence that Donaldson could have been released on temporary home visits and furloughs (A. 100-102). However, such temporary options are not the same as permanent release and are only other forms of treatment. Respondent further points to O'Connor's refusals to release Donaldson to his friend Lembcke (A.210, 221, 229) and the Helping Hands half-way house (A.208), as additional evidence of malice upon which the judgment could stand. Such reliance is misplaced. O'Connor was not empowered to make such a release where the patient was not recovered. Copies of staff conference reports in the Appendix show that refusals of release were not the work of Dr. O'Connor and Dr. Gumanis alone. (A. 194-198, 207-208, 214-229).

Petitioner submits that he should be immune from damages in a situation where he was acting in good faith, according to accepted institutional policy and procedures, and could not reasonably be expected to foresee the future emergence and enforcement of a constitutional right to treatment. State employees should not be exposed to personal monetary liability for acts subsequently condemned as unconstitutional by the recognition of a new constitutional right.

The District Court erred in not directing a verdict in favor of Petitioner after having heard the evidence. The question of liability of Petitioner should not have reached the jury. The evidence reflects that Dr. O'Connor acted properly within the statutory and constitutional framework as it existed then. He should not be penalized in retrospect for actions taken in good faith within the scope of his authority as a hospital superintendent or for judgments made as a physician. Such retroactive application of an emerging constitutional doctrine works great injustice. The judgment of the Court of Appeals should be reversed.

Conclusion

For reasons and under authority set forth above, this Court is respectfully requested to reverse the judgment of the Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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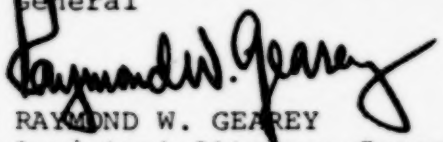

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